COUNTERTRANSFERENCE AND SELF-DISCLOSURE OF CREATIVE EXPRESSIVE THERAPISTS

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Abstract: *In the optimal treatment situation, therapists need to put their needs aside and do their best to support and help their patients better cope with the suffering and difficulties they are experiencing. In this process, the emotionally charged issues that arise during the interaction between the therapist and the patient can elicit in the therapist strong feelings related to his or her personal world and the issues that concern him or her (countertransference reactions). In the creative expressive treatment,, this phenomenon can be especially strong due to the more primitive and symbolic content that emerges (Link-Scoop, 2013). There have been only a few previous studies that have examined the phenomenon of countertransference and what helps creative expressive therapists to deal with it. The current paper that presents some of the larger research (which included comparing creative expressive therapists with speech-based therapists) is focused on examining the issue of self-disclosure. We will examine whether and how it is appropriate to reveal their countertransference reactions and their sources to patients and what the positive and negative consequences of such exposure may be. The findings of the present study could provide creative expressive therapists with tools to help them decide whether to disclose their emotions during a therapy session and how best to employ these tools.*

Key words: *self disclosure, therapy, countratransfer, emotional state of the therapist.*

According to the total approach, countertransference encompasses all the therapist's emotional interpretations of the patient's therapeutic process, arising from his or her world and self as a person and exceeding what he or she defines as proper professional behavior (Goldstein,2007). Countertransference includes all of the therapist's conscious and unconscious emotional responses, those neurotic and reality-based, those created in response to the patient's transfer and those that arise in response to everything else that happens in the therapeutic process (Bernard, et al., 2008). In examining the phenomenon of countertransference, it is common to examine a number of its aspects: origins, triggers, manifestations, consequences / effects, and the ways in which the therapist manages countertransference.

Sources refer to unresolved conflicts or personal experiences that arise in the therapist during the countertransference. For example, a source may be personal experiences of the therapist with his or her family (his or her role as a parent or his or her relationship with his partner), or his or her professional self-image (Hayes & Gelso, 2001; Rosenberger & Hayes, 2002); Erosion, overload, or financial difficulties (Goldstein, 2007). Jung argued that the weak points, neurosis, or psychological disorders that exist in the therapist are the ones that give him or her the power to heal others (Jackson, 2001). He used the term "injured therapist" to refer to therapists whose personal experiences and suffering they experienced helped them develop a positive sensitivity and attitude towards the people they care for (Jackson, 2001), the opinion that contributes significantly to the patient's therapeutic process and improvement of their condition (Miller & Baldwin, 2000). The underlying premise of the 'injured therapist' theory is that empathetic and sensitive listening can only occur if the patient's words have meaning for the therapist (Jackson, 2001).

Causes or triggers for countertransference may be therapeutic content tangent to the issues that concern the therapist, similarities between them and the patient, or the process of therapy and interaction between the therapist and the patient (Baehr, 2004; Hayes et al., 1998).

Expressions of countertransference may be internal - the therapist's thoughts or feelings - or external, expressed through a wide range of verbal and nonverbal behaviors (Perlov, 2009).

Anxiety is the most common of the negative emotions that arise from countertransference. It usually results from the therapist consciously or unconsciously perceiving that some aspect in the therapeutic situation is posing a threat to him or her and is felt as emotionally overwhelming (Hayes & Gelso, 2001). Countertransference may also be reflected in the negative and problematic behaviors of the therapist that will arise from thoughts and feelings that are triggered in him or her without an awareness of the emotional process he or she is experiencing. These behaviors are generally divided into two groups: avoidance behaviors, which will be reflected in maintaining emotional distance between the therapist and the patient and low mental involvement in the patient's therapeutic process (Rosenberger & Hayes, 2002).

Another important element in examining the phenomenon of countertransference is its consequences or effects on the therapist and his or her practices. On the one hand, countertransference may have positive effects: it will increase the therapist's empathy, identification, or understanding of the therapeutic process and dynamics, and will improve the interaction between the therapist and the patient, reducing the distance between them. On the other hand, countertransference may have negative effects on the treatment process and on the patient (Goldstein, 2007; Perlov, 2009; Hayes & Gelso, 2001; Rosenberger & Hayes, 2002). When the therapist responds to treatment out of his or her

unresolved conflicts rather than the patient's needs and is not focused on the emotional process the patient is undergoing, the efficacy of the treatment will impair (Hayes & Gelso, 2001). Personal distress experienced by therapists can have a negative impact on their ability to perform their work effectively (Sherman, 1996) and it will make it difficult for them to feel empathy for their patients (Cain, 2000). Countertransference can also affect and distort the way the therapist perceives the patient, his or her behavior, and the decisions he or she makes during treatment (Rosenberger & Hayes, 2002).

Creative expressive therapists are exposed to many stronger and more powerful countertransference responses than speech-based therapists (such as cognitive-behavioral) due to the many layers (e.g., verbal and non-verbal) and the various senses involved in treatment (Homeyer & Morrison, 2008). As with other treatment methods, countertransference responses in creative expressive therapy may increase the therapist's sense of identification with the patient to an exaggerated level that may adversely affect his or her professional abilities. This can happen especially strongly in cases where the therapist experiences emotional difficulty similar to that of the patient. It will often be difficult to contribute to the patient's creative process - such as suggesting ways to change the presented situation or ideas on how to promote the work he is working on, thereby hindering his progress (Phillipose,2003). In addition, these responses from the therapist may make it difficult for them to be fine-tuned and attentive to the process the patient is undergoing. That is, in some cases, due to the internal process that he or she is experiencing and /or emotional flooding, the therapist will lose the viewer's position in the process undergoing the patient and will have difficulty separating his or her past experiences from the reality of "here and now" and his or her relationship with the patient. One possible outcome of this process is that the therapist fails to respond quickly enough to the processes described by the patient

and to significant issues that he or she brings up, which might hinder his or her development in treatment (see, e.g., Nissan, 2005; Phillipose, 2003). It is important to note that there are differences between creative expressive therapists in the way they relate to their countertransference responses. Some recognize these reactions and address their causes and outcomes outside the treatment setting, either on their own or with the help of guidance. Other therapists express them with the help of the artistic medium, while others deny their existence and do not believe that they can have negative effects on treatment (Link-Scoop, 2013).

The last aspect in which it is customary to examine the phenomenon of countertransference relates to the way the therapist manages it. The prevalent approach to the management of countertransference today relates to the therapist's ability to maintain a balance between the two extremes described by Recker. That is, on the one hand, the therapist needs to remain emotionally connected to himself or herself during his work. On the other hand, the therapist should not allow his or her countertransference reactions to negatively affect the patient and his or her treatment process (Latts & Gelso, 1995). According to research in the field, the most significant element in the proper management of countertransference is the therapist's self-awareness. In order to do his or her job well, it is important for the therapist to observe and assess his or her feelings, memories and behaviors during his or her work and to examine how they come from his or her personal life (Hayes, 2002; Jackson, 2001). To this end, the therapist must be willing to actively explore his or her personal history and try to understand more in depth the events that have had a significant impact on him or her (Hayes, 2002).

The therapist must also recognize the personal challenges he or she faces today (Hayes, 2002; Jackson, 2001). It is important to note that therapists differ in

the way they treat their self-awareness during their work. Some therapists are aware of their mental problems, feelings and thoughts and are working to protect themselves from providing ineffective, inappropriate, and unethical treatment as a result. Another group of therapists is aware of mental issues that concern them but are not working to take care of themselves and find ways to deal with them better. Therapists in the third group are not at all aware of the processes or mental difficulties within them, which increases the risk of unethical behaviors (Carroll, Gillroy, & Murra, 2008). In addition, this denial often creates blocked areas of treatment, inaccessible to the therapist's process and emotional disconnection from the patient (Antman-Tamari, 2010).

It is important to emphasize, however, that the therapist's awareness of his or her own vulnerability is a necessary step, but not sufficient to positively affect the therapist's vulnerability to the therapeutic process. In addition, the therapist must resolve these conflicts at least partially and become less absorbed and engaged in them or he or she may find it difficult to be sensitive and empathetic towards the patient (Hayes, Yeh, & Eisenberg, 2007). Another important tool that can help therapists deal with countertransference reactions is training. Training can provide the therapist with support and guidance during their work, help them identify and understand mistakes or failures, and help them decide how to deal with specific ethical or clinical difficulties (Richards, Estelle, & Muse-Burke, 2010).

In addition, training can help therapists deal with their own personal issues or difficulties and prevent them from influencing their work (Springman-Ryback, 2007; Homeyer & Morrison, 2008). Therapist guidance for creative expressive therapists can also include artistic tools (artwork or metaphorical play) to enable the instructor to view non-verbal elements of guided therapist behavior and not just what he or she can express in words. This process can help the counselor

better understand the process the therapist is undergoing and thus be able to help him or her significantly improve his or her work (Gil & Rubin, 2005; Homeyer & Morrison, 2008). Another method used by expressive and creative therapists to deal with countertransference reactions is to practice art to release strong emotions (such as frustration, distress, or even satisfaction) or to understand and process unexplained feelings such as irritability, fatigue, emotional reactivity, or post-meeting arousal. Several studies have found that using artistic tools has enhanced the professional efficacy of expressive and creative therapists, expanded the way they perceive their patients and the therapeutic process they undergo, reinforced their empathy for them and their ability to contain and cope with difficult substances (Brown, 2008; Fish, 2012 ; Gil & Rubin, 2005).

One of the specific tools for dealing with countertransference responses examined in the present study is self-exposure. This is an issue that many therapists face (Maroda, 1999). A therapist's self-disclosure can include his or her countertransference responses in the therapeutic “here and now.” Exposure of the therapist's countertransference responses can serve several purposes, including helping patients cope with their mental reactions by revealing that the therapist also has vulnerability in this topic and detailing how he or she has coped with it. Self-exposure can also strengthen the interpersonal relationship between the patient and the therapist while emphasizing the therapist's humanity to strengthen the patient's trust in him or her, his or her sense of trust and empathy and positive feelings towards him or her. Self-exposure can reduce the patient's feeling that he or she is completely alone in his or her feelings and that no one can understand his or her mental reactions. Self-exposure can encourage patient’s discovery and self-inquiry, especially with regard to interpersonal relationships. It also strengthens his or her self-esteem. Self-awareness helps demonstrate mutual emotional communication that the patient can apply in other relationships in his or her life.

The therapist's self-exposure can also help patients identify and label emotions and enable unblocking or therapeutic blasts (Baehr, 2004; Maroda, 1999; Ziv-Beiman, 2013).

According to the research in the field, exposure should include only information that is appropriate for the patient and can contribute to his or her therapeutic process. It must be real but constructive, not negative or too burdened with emotions and relatively short (Henretty & Levitt, 2010; Maroda, 1999). Exposure of countertransference responses has been found to contribute to positive and intimate therapeutic relationships, better treatment outcomes, and patient's perception of the therapeutic relationship as a significant place that can bring change (Maroda, 1999).

Another type of self-exposure is that of the therapist's experiences outside the treatment room, such as biographical details, personal understandings, or coping strategies. Regarding this type of exposure, there is no broad consensus among therapists whether it is appropriate and whether it does not contradict the principles underlying the therapeutic relationship. On the one hand, self-disclosure of this kind has been found to have a number of positive effects:

• reducing inhibitions and unrealistic fears that make it difficult for the patient to manage interpersonal relationships;

• reducing negative or problematic behaviors on his or her part;

• motivating the patient to perform behaviors that require effort from him.

Cases in which the therapist discloses personal information about himself or herself without following a direct request from the patient or in connection with a particular therapeutic content are viewed particularly negatively (Maroda, 1999).

In creative expressive therapy, therapists have another channel of self-exposure; that is, they expose themselves through their participation in the patient's artistic process (e.g., musical improvisation). By using art, the therapist can also take an active and direct part in the patient's world. In such a process, there is a greater opening to the therapist's countertransference reactions which may be reflected in his nonverbal behavior and artistic actions. Awareness of the emotional processes he or she undergoes may help the therapist to control his or her transference responses and choose which ones to disclose to the patient (Dillard, 2006; Fish, 2012; Landy, 1992; Lewis, 1992).

Methods

The present study includes semi-structured interviews with 10 creative expressive therapists (most of whom are art therapists), who have at least five years of experience in the profession, working in various settings with diverse populations - adults and children. Except for one interviewee, the researcher had no prior knowledge of the interviewees. The interviews lasted about an hour, were recorded and transcribed. All therapist names mentioned in the article are pseudonymous in order to maintain their confidentiality.

Findings

The analysis of the findings shows that some therapists believe it is important for patients to reveal their feelings in the 'here and now' treatment. According to them, when this exposure is done in a targeted manner related to the patient's therapeutic process, it can contribute to the real connection between the therapist and the patient and bring them closer together. In addition, they stated that such exposure can help the therapist to examine how much the emotions they are experiencing are related to their internal experience or the patient's process. This diagnosis can help the therapist focus on the patient and their needs. As far as the patient is concerned, hearing about the feelings that arose in the therapist

during their interaction can give him or her an idea of how other people feel about him or her, which can promote his or her interpersonal interactions.

Hadas: "I think that, to some extent, there should be a disclosure, words should be spoken, tried to be spoken as if these things are related, as if they are entirely related to my personal world or what has happened in the room. I think it's important, without revealing it sometimes without revealing it can be a lie which is not a real place in the room and it won't bring growth. I think to a very high degree, I mean, to bring myself and my story, but the feelings that at the moment, I feel, I don't know, what it is even if it's fatigue for that matter and bring it up as if, you know, I notice I'm feeling terribly tired I wonder if it belongs to me or you. "

Some therapists noted that it took them a while to feel confident about exposing their feelings to patients and be less concerned that such exposure would impair their relationship. This concern stems in part from the history of psychological therapy, which emphasizes that the therapist should be a neutral board and not personally involved in the therapeutic process in order not to adversely affect it. Therapists are also more likely to find it difficult to define for themselves the logical limits of self-disclosure within their relationship with the patient to maintain their professionalism. That is, when exposure makes their relationship unprofessional and when exposure is significant and relevant to treatment.

Aya: "In the past, I was really scared to say, use these things and nowadays I increasingly rely on myself. I am more daring, when it suits me to say that I feel so and so.

I think it's very significant what I feel and sometimes it's things that patients are there and sometimes they prefer to close their eyes and not want to see and I think they can already see it."

The creative expressive therapists that were Interviewed noted that the artistic way of expressing their feelings in response to the therapist's work made it easier for them to reveal their feelings in the therapeutic 'here and now'. They felt it was a more secure and authentic exposure. This exposure helps them connect with the patient from where they are and gives them another perspective on their inner experience.

Hadas: "Many times, I will bring what I feel out of artwork. As if a patient can look at the painting and say: I do not know, but it brings some emotion that is very different from mine and I can tell that it is really very scary or I get some or other feelings from it ... Many times in art it is as if I have opened a very direct way of connecting, connecting with art from the most authentic place."

Jordan: "I will say a lot about paintings. Things I feel are not about work ... Yes, but I will try to say it in the same way as you say I feel, I feel colorful here so it is very vivid, I feel like this turtle is a bit self-sustaining, maybe as lonely as I would suggest…"

However, some therapists stated that they completely refrain from disclosing their personal feelings and thoughts to patients in order to maintain therapeutic boundaries and a proper distance between them. For example, Nirit usually does not share her personal experience with her patients, unless she has to do so to show clear boundaries.

Nirit: "This kid I have to set boundaries tells me like he wants me to shut up so he can – sh sh sh I said. Now I say what you said? At first I played like I didn't really understand what he was saying.. It took a while before I realized what he was saying to me and then, with the help of the instruction, I began to say to him: 'Listen to me, it is inappropriate for you to talk to me like that, it is unpleasant to me. I disagree."

Concerning revealing their feelings in the therapeutic “here and now”, about disclosing similar personal experiences to a patient, there were differences among the interviewees. Some have noted that in cases where they have successfully coped with similar personal experiences, they chose to share them. According to them, such exposure can bring them closer together, normalize the patient's experience, and strengthen the patient's confidence in their ability to understand and empathize with the therapist. Here is some example:

Hadas: "In other places, as if from a place of more discourse, so yes I can sometimes also bring examples from my personal world, if I suddenly for a moment connect with something, I do not know, what is something mother-child connection, say. Then, I can suddenly tell about situations that happened to me with my children, sometimes as if in some example. I feel that especially with young people at this age, it can very often help connect to normative feelings and bring about something both myself and my world through things I have been through. "

Nimrod: "Then he told me ... and he has a chronic kidney problem and showed me the button and told me it was very manageable and disturbing to him and then I shared my personal experience. For example, at the end of my military service, I had a simple car accident and injured my left hand,, And I'm left-handed. I was a very good basketball player with high scores, and I was a talented artist. I was always a left hander. I was 'flying' at the age of 20, I was a little egocentric and very proud. I thought I was beautiful and knew everything and suddenly fate came and injured my hand and I was going to lose it. for another minute and I shared it with those feelings and this brokenness and that feeling of OK, something came, fate came, and hit me in the face.. And I went through a very serious rehabilitation, it's not that not every day, I've stopped thinking about

it ... the most It's good to be empathetic to it, to actually create something that is shared, to be called the Disability Brothers. "

Yonit: "I'll tell you this way when I was, until second grade, I couldn't read, I had a learning disability, probably, and I learned orally, and I would manage well, surviving ... What I do a lot of times I say: 'you know I didn't know how to read in second grade and you know today I am different.' As if I was there, I know that, I feel it and that's why I also know how to help."

Some therapists have mentioned that one of the issues they can especially bring from their personal experiences is their role as parents. Identifying from this place is especially significant in connecting with patients and helping to perceive the therapist as a person like them who has experienced similar things and his or her advice comes from his or her own experience.

Nimrod: "I sit with divorced parents who talk about the child and make all the possible mistakes with the child. So I meet parents as a child to divorced parents, as a divorced parent, which means there are connections here from all sides and I often share my experience with them. I show them that we are in the same boat, I know it, I have experienced it. I mean, for the first year, I cared without being a parent, it was simple. I look at it in retrospect how parents brought their child to a therapist that had no experience as a parent. And at some stage as a parent, I can connect with the parent in me. Even when I speak with parent guidance or teacher guidance, I often bring examples of my children."

According to the interviewed therapists, in deciding on exposure to personal experiences, it is important to take into account what is appropriate for the patient - whether exposure can contain or expose problems and block progress in therapy. What is required from the therapist at that stage in the treatment: is he or she required to be a strong and contained figure? Should the patient still be angry with the therapist or is he or she at the stage of the treatment that he or she

can see the therapist as a human being in his or her own right? Another question is how strong and stable their relationship is. Does the patient have a sense of trust that he can trust the therapist to do what is right and good for him or her? Examining the answers to these questions can reduce negative effects of self-exposure and increase its positive effects on the patient. At the same time, the examination process can influence a decision of self-disclosure that is designed to satisfy a patient's needs to share with someone else his or her experiences.

Amalia: "With young patients, I sometimes have to think about when they can contain ... I use self-disclosure only when I feel that someone in front of me can do something with it, not just release. Because the patient is not always capable of direct exposure, sometimes he or she needs that distance; sometimes he or she needs me to be strong and sometimes he or she needs to feel at the center of my attention. I try not to do it where I feel that someone still has to feel angry about it, too, because in the places I do it, it scares them off from their empathy and their closeness and then it paints me in a way that is difficult ..."

Yonit: "There are children with whom I share and some children with whom I do not share. I am often very honest with them, with the people I meet. But there are children that if I tell them something personal, they might feel scared."

Ricky: "If a child is a little older, I can share a bit, but at times it fits in, not where it can block but allow the relationship to develop a bit, you see I am very calculating. I do not reveal many emotions."

Another consideration that influences therapists' disclosure of their personal experience is how emotionally charged it is for them. They try to avoid emotional awakening during their work and avoid overloading the patient. Here is an example:

Nimrod: "Sometimes, situations happen in the treatment that I am afraid of, that I do decide here I do not enter, too dangerous for me, and not necessarily dangerous to the therapist, now it is dangerous for me. I mean that's part of the thing. The therapist needs to know well when to take care of himself, playing with fire is not necessary"

Ricky: "My mother immigrated from Yemen. This is very reminiscent of Ethiopian immigration, and this girl's story very reminds me of my mother's story, who went to boarding school because was an orphan. The experiences she passed on to me and a lot of pain that I went through when I was a child. So at one point I didn't spill it in therapy, but then I brought it up. It was important to tell her: yes I have a story too, you know? Yes? There are other people around us, and there is a good future for people around with stories like yours. I think by sharing this, I felt like I was putting it in a processed place. So, yes, it does work; When I think of parents, the ones with whom I can share the conflicts that have accompanied me from my past in my parenting, I think it's mostly contributing and bringing them closer to me, making them feel less guilty. There is someone empathic on the other side who knows these situations and conflicts. That is something liberating I think, I didn't feel it was blocking."

The interviewees referred to a number of cases where self-disclosure had a negative effect on the patient and the treatment process. One case in point is when the exposure was made in response to the patient's pressure rather than the therapist's thinking that exposure was most appropriate for the patient and his or her therapeutic process. Especially when working with children, the therapists noted that they often want to know more about them and tend to ask a lot of personal questions. Jordan describes the pressure she felt on the part of a patient and the difficulty of refusing to answer, even though she knew deep down that the right step was to maintain clear boundaries between them. She describes how in

the end she gave in and answered the girl's questions, feeling strong negative feelings of distress, anger, and helplessness.

Jordan: "I remember one girl, I am still working with her for a second year. She started bombarding me with a million questions. I felt that she was a little imposing but I found myself just answering her and that was… I came out with a very complex feeling from this meeting, a little bit attacked but also a little this is it like that ... and she touched on there which was a point that would have hurt me but it also kind of made me laugh. In the end, because she had also tried in my mind last time and I did so, and then a simple meeting I just walked into the corner I have to admit and I was not a big name, I was helpless there, I do not know why and if it was related ... "

Another condition that therapists have noted that gives them strong negative feelings is sharing an experience that is still emotionally charged for them. They noted that even when it seemed to them that the exposure was appropriate for the patient and at that certain stage in which they were being treated, they were distressed because the experience they described was unprocessed by them. Sometimes, they decide to expose the experience even when it is still charged with a desire to express a connection to the patient and what he or she is experiencing. Here are some examples:

Aya: "I felt a little shaky because I revealed something very personal not only about myself but also about my son. You know it's not my mother that she's dead already and I have no problem... that she's there, but I said something that no one knows, very privileged information. You know, like I told myself and in retrospect I felt it was just right that it worked."

Hadas: "Sometimes, it can really upset me, if it is true. As if sometimes I feel that it is very right to bring this exposure. It is simply not necessarily because

of the result but because it seemed very psychodynamic about what is right and wrong and how much the therapist is supposed to be ... I get very confused by not knowing what's right and wrong, like finding myself exposing myself far more than I planned to expose myself. It's like connecting."

In addition, when self-disclosure does not match the patient's ability to contain, this can create a feeling that the patient cannot trust the therapist and thus impair their relationship and even create emotional disconnection and delay the progress of treatment. Here is an example:

Hadas: "There are times when I can recognize that this was wrong. It doesn't close, has gone, left but it suddenly comes down to being disconnected. It was wrong. But every time I think of one of the things I learned Is that really when? At what stage of the relationship can I bring myself more, at this level I ask myself when this happened. I don't remember at this time a situation that completely detached me from a problem that really couldn't be worked out like that, but sometimes it can cause a sudden detachment inside the therapy room."

Exposure to similar experiences of the therapist may also have positive effects on the patient, the treatment process, and their relationship. First, exposing similar personal experiences of the therapist, when tailored to the patient's ability to contain and not emotionally or personally charged, can help the patient directly deal with that experience: provide him or her with another perspective, normalize it, and legitimize other people's experiences as well. It may give him or her hope that he or she can deal with problems successfully, too.

Aya told how her self-disclosure about how she coped when her son experienced a difficulty similar to that of her patient, helped the patient accept that he needed help and achieved his cooperation by caring for her.

Aya: "I will tell you something very personal. My son has fears, and I said to myself I will take him for treatment. He had fears at night: when falling asleep at night, he had nightmares. Now my patient also had nightmares of a different kind but he also had bad dreams, and then I told him you know there is .... And I said I will take my son, this anxiety psychiatrist .... I told him I went through a process. I checked that it was a great place. I said this is where I will take my son. This is the most suitable place, and my patient just made a switch."

The therapist's self-disclosure can also encourage self-disclosure on the part of the patient, helping him or her open, share and talk about similar personal experiences, feelings, and issues which he has previously had difficulty talking about. This can contribute and deepen treatment. One of the reasons for this is that the therapist's exposure presents him or her with a different communication model, showing him or her how to talk about feelings and personal experiences in an open and honest way.

Jordan: "There can be places of identification. For example, I remember here in the room some individual treatment I did to a girl with divorced parents, whose main issue was really a loss of the grandfather who was very, very close to her heart. She experienced the loss very hard. And I'm also a daughter to divorced parents and at some point, I shared it with her. I think it very much created her ability to say something about it because it was from such an unspoken subject, the grandfather. It actually opened something up. So I think it was a place to share."

Also, in the case of a child, self-exposure of the therapist can provide him or her with a remedial experience, of more mutual communication with another adult. Here is one example:

Nimrod: "Sometimes, as a therapist, I give my patient a model he or she doesn't have at home. He or she has two parents who have no emotional habits at all. Suddenly a grown man comes with him from a completely different world and shares it with things the parent doesn't even think should be shared. So, I give the patient some sort of remedial experience of a model because he or she looks at me as if I were an adult. He or she listens to me, coming every week. I am a professional therapist and suddenly I show him or her something different. So sometimes I reveal my feelings more because I know that kid will have a remedial experience here."

Discussion

The interviewers referred to two distinct types of self-disclosure: the exposure of emotion in the “here and now” and the exposure of experiences similar to those of the patient. Most therapists noted that it was important to expose their patients to their "here and now" treatment. They say such exposure can contribute to the therapeutic process and their relationship with the patient.

These findings are supported by previous studies (Baehr, 2004; Goldfried, et al., 2003; Hayes & Gelso, 2001; Ziv-Beiman, 2013)). For example, according to the intersubjective approach, the basis of the therapist's empathy and emotional adjustment to what the patient experiences is the use of his or her own subjectivity to understand the process the patient is experiencing and to support the patient's subjective observation of himself or herself and his or her behavior with other people in his or her life (Maroda, 1999; Ziv- Beiman, 2013). Similar to previous studies, the interviewed therapists indicated that it was convenient for them to perform such exposure through work (Dillard, 2006; Fish, 2012;).

All interviewed therapists argued that in some cases, they should disclose personal experiences similar to those the patient is undergoing to emphasize their ability to understand them and be empathetic toward them or to receive feedback

on the extent to which their intervention is appropriate for that patient and does not derive from their personal processes. According to all interviewees, therapist self-disclosure can have negative and positive effects, depending on the conditions under which it is performed and to what extent it is appropriate for the patient and his or her needs in the treatment. Exposure should be done in the appropriate timing and should include only exposure of content that is not emotionally charged for the therapist. When the exposure is made under the right conditions and through a conscious and careful decision by the therapist, it may contribute to the patient's treatment process and the relationship between him and the therapist. This finding is consistent with the research saying that the exposure of feelings in the “here and now” treatment may help the patient to cope with the similar experience he or she is going through, normalize it, and give the patient a feeling that he or she is not alone in this process and that the therapist understands him or her, thanks to own experience (Baehr, 2004; Maroda, 1999 ; Ziv-Beiman, 2013).

However, when exposure is done under the wrong conditions and for the wrong reasons, it can overload the patient, jeopardize the treatment process, and damage the therapeutic connection between him or her and the therapist. At the same time, such exposure can overwhelm the therapist emotionally and make it difficult to separate his or her personal experience from the patient (Henretty & Levitt, 2010; Maroda, 1999; Tsai, et al., 2010).

According to the findings of the present study, exposure of the therapeutic "here and now" or immediate countertransference reactions during a therapy session appears to be generally beneficial and can contribute to the patient's process and the relationship between the therapist and the patient. Therefore, therapists should try to reveal to the patients what is right for them and their relationship with them, what they feel and experience during the treatment

session. It is found that when this exposure is made appropriately and in a way that contributes to the patient. Self-exposure can help the patient understand more about his or her emotional experience and how other people perceive him or her, interacting with him or her.

In contrast, the exposure of similar personal experiences the therapist has undergone can have both positive and negative effects. In order to increase the likelihood that such exposure will have positive effects, it is important that it be spot on, directly connected to the process the patient is undergoing. Self-exposure should be matched with its containment, to integrate the treatment done in a humorous or relatively light manner. It is especially important to try to avoid self-exposure of emotionally charged issues, exposure that results from stress or inappropriate behavior of the patient, or too frequent exposure that violates therapeutic boundaries. According to the interviewees, the decision about self-disclosure, especially of similar personal experiences, is complex and requires finding the right balance between focusing on the patient and bringing in the perspective or experience of the therapist. Each therapist learns from his or her experience how best to do it and contribute most significantly to patients but to some extent this process needs to be re-structured with each patient and adjusted according to a stage at which the treatment is situated.

It is important to note that the present study did not include a representative sample of expressive and creative therapists but only 10 therapists who volunteered to participate in the study and was done in a qualitative way that may be influenced by the way the psychodrama practitioner perceives and experiences the topics discussed. In addition, the study was conducted at only one point in time and therefore did not allow for changes in therapists' attitudes toward self-disclosure. Different patients and the degree to which the content they upload are relevant to the individual's own processes or experiences may affect the extent

to which the therapist chooses to reveal his or her personal experiences and the effects of those experiences. Examining multiple time points would have allowed more in-depth examination of the factors affecting the decision to allow self-disclose and its implementation process. In addition, the research extended in time would also allow me to examine how life circumstances or emotional burdens in the therapist's personal life affect his or her tendency to reveal personal experiences or feelings in therapy and his or her ability to do so in a manner appropriate to the patient and circumstances. A deeper understanding of this issue will allow therapists to give more specific tools on how to conduct self-disclose in situations where they are particularly busy.

Another question that can be of interest is comparing relatively experienced therapists (over 15 years) with new therapists in the field in terms of self-exposure and its implications. Such a test will help understand more about the difficulties experienced by therapists-beginners with the decision to reveal personal experiences and how they are better able to cope with the experience.

In conclusion, it is worth saying that self-disclosure of feelings in the "here and now" and relevant personal experiences of the therapist is a significant tool that can contribute to the therapist's ability to understand and empathize with his or her patient. Examining and discussing the benefits and potential dangers of using it can help creative expressive therapists to consider how to do it right and make the most of it. As a result, their ability to establish a close relationship of trust and empathy with their patients will be strengthened and will help them through a meaningful psychological process.

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